

THAILAND/BURMA HEALTH AND EDUCATION ACTIVITIES REVIEW

HEALTH ACTIVITIES FINAL REPORT

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The views and recommendations expressed in this report are solely those of the MSI Evaluation Team and are not necessarily those of USAID or the U.S. Government.

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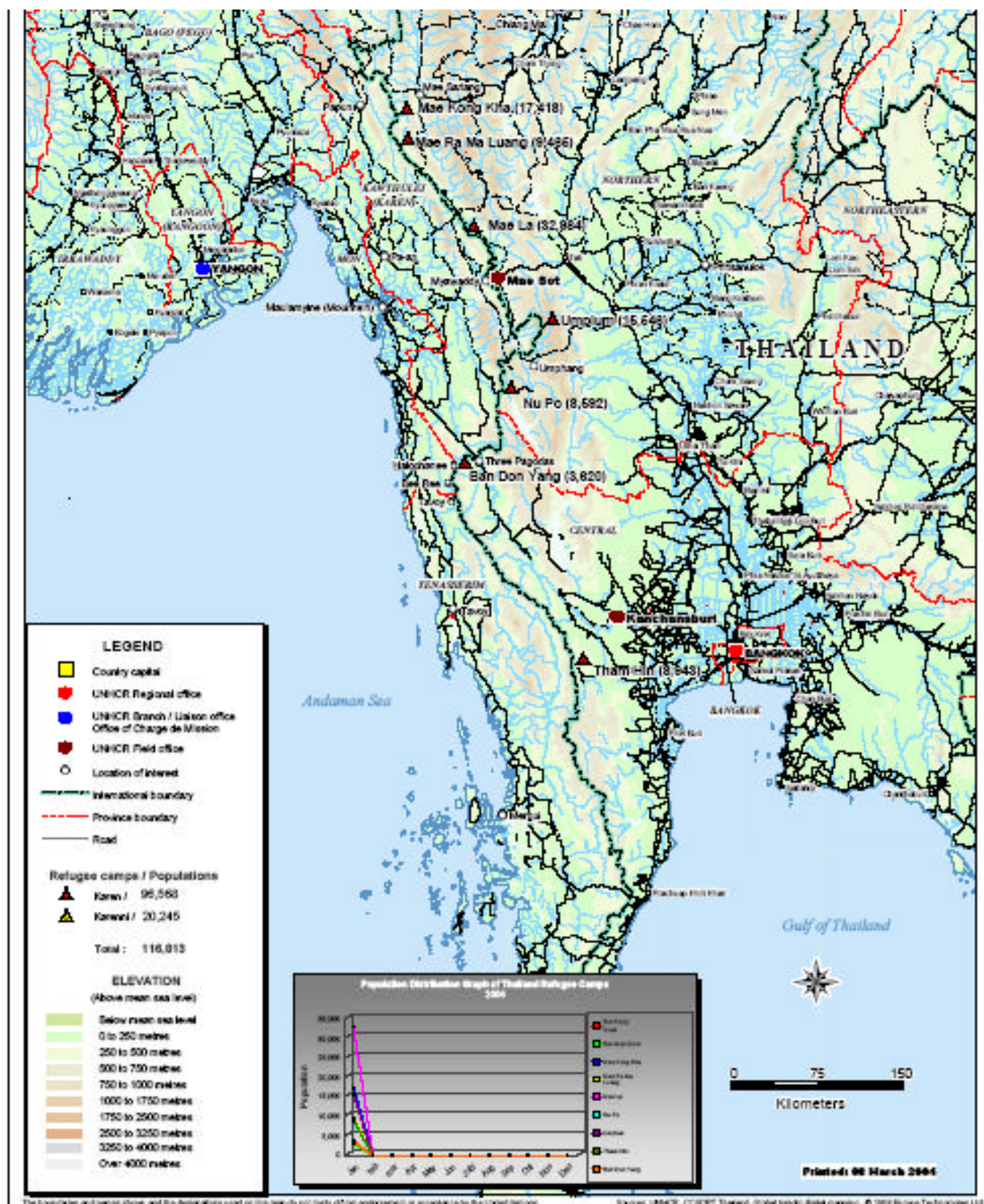
Acronyms

AMI*	Aide Medicale Internationale
A/N	Antenatal services
ARC*	American Refugee Committee International
ARI	Acute respiratory infection
AusAID	Australian Agency for International Development
BBC*	Burmese Border Consortium
BRC	Burmese Relief Center
CBO	Community based organization
CCSDPT	Committee for Coordination of Services to Displaced Persons in Thailand
Consortium*	World Education/World Learning Consortium - Thailand
DFID	Department for International Development, United Kingdom
ECHO	European Union Humanitarian Office
EPI	Expanded Programs on Immunization
HI*	Handicap International
HIS	Health information system
HW	Health Worker
IDP	Internally Displaced Person
IOM	International Organization for Migration
IRC*	International Rescue Committee (Medical, MCH, PH, WASAN, shelter)
JRS*	Jesuit Refugee Services
KNU	Karen National Union
MCH	Maternal and Child Health
M&E	Monitoring and evaluation
MHD*	Malteser-Hilfsdienst Auslandsdienst E.V.
MOI	Ministry of Interior, Thailand
MoPH	Ministry of Public Health, Thailand
MSF*	Medecins Sans Frontieres
MSI	Management Systems International
MW	Midwife
NGO	Non-governmental Organization (alternative: PVO)
NLD	National League for Democracy, Burma
ORS	Oral Rehydration Solution

ORT	Oral Rehydration Therapy
PHC	Primary health care
PRM	Population, Refugees and Migration, State Department
R/CH	Reproductive and Child Health Care Program
RFA	Request for Assistance
RTG	Royal Thai Government
SOW	Scope of Work
SPDC	State Peace and Development Council (Burmese regime)
SYNG	Shan Youth Network Group
TBA	Traditional birth attendant
UNHCR	United Nations High Commission for Refugees
UNICEF	United Nations Children's Emergency Fund
USAID	United States Agency for International Development
WHO	World Health Organization

* Members of CCSDPT

Map of Border Provinces and Nine Refugee Camp Locations



Executive Summary

This health assessment was conducted to provide USAID/RMD/A with information about refugee and migrant health needs and recommendations for future programs. The assessment team included an education and a health specialist who prepared separate sector assessments. Individual NGO performance was not evaluated. During three weeks in Thailand (9/16-10/9/04) the team reviewed documents and interviewed informants from donors, NGOs, camp and clinic programs, and indigenous (Karen, Karenni, Shan) staff and committee members. They visited three large refugee camps that contain 60% of the area's camp population, a major Burmese-operated clinic program in Mai Sot, and various satellite and outreach programs in Tak, Mae Hong Son and Chiang Mai provinces. They also reviewed information about cross-border programs for IDPs living in Mon, Karen and Karenni states with program supervisors.

Accomplishments

1. The camp curative and preventive services are appropriate and effective, with excellent reductions of illness, acute malnutrition, and mortality rates.
2. These results are due to good training, adherence to guidelines, and careful surveillance of disease rates, high vaccination coverage, high quality water and sanitation services, and high staff morale.
3. IRC and other NGOs are committed to capacity building. Camp committees and departments have taken over important tasks, including food distribution, staff reimbursement, and planning future activities, including eventual repatriation. A variety of staff has been trained to provide appropriate personnel for clinics, support services and management.
4. The Mai Tao Clinic in Mai Sot under Dr. Cynthia Maung's leadership has generated an effective mix of programs. These include local clinic services, linkages to Thai hospitals, outreach programs including cross-border, and extensive training in several disciplines. The center provides an important source of effective health care for migrants. A visionary Back Pack Medic Team program is supporting 70 teams that work in Mon, Karen and Karenni states with a target population of 150,000 ethnic Burmese.
5. A pilot Migrant Health Project in Tak Province attracted 25,000 migrant visits in one year, and helped reduce a local hospital's workload by one third.
6. There is a high level of collaboration and unity of purpose among registered refugee NGOs and their Committee for Coordination of Services to Displaced Persons in Thailand, CCSDPT.

Conclusions and Recommendations

USAID and other donors agree that the camps are well run and effective. Camp refugee health status is far superior to that seen in Burmese populations outside of the camps and comparable to the level of health of the general Thai population. Outside of camps, Burmese migrants have

significant health problems. They live in a hazardous environment. They receive low wages, fear deportation, and lack access to health services. An expansion in migrant health programs is justified to address their needs.

Furthermore, there is a modest shift in Thai attitudes toward migrants. The RTG has increased the number of temporary migrant work permits and are screening some migrant workers because of concern about transmission of malaria, tuberculosis, and HIV. Across the border, IDPs in Burma suffer from much higher rates of communicable disease, malnutrition, and maternal-child mortality rates. As health and education are recognized as sustainability factors for successful repatriation, additional Thai support may occur.

To maximize any efforts to expand migrant or cross-border health programs, donors need to increase cooperation to share information and set priorities. Donor collaboration would result in the effective leveraging needed to gain MOI approval of more vocational training, worker certification, and expanded outreach programs. Donor cooperation will be important in formulating strategies for eventual Burmese repatriation.

Camp refugee recommendations

1. Support should be maintained for camp training, supervision, and indigenous committees; all major factors in the improvement of refugee health status. Health worker training in camps and at Mai Tao Clinic have produced a large number of competent clinical and support personnel. These efforts have been complemented with useful guidelines and treatment manuals. Support should be continued to update and distribute these materials.
2. Camp committees are increasingly responsible for important administrative and management tasks. They are currently comprised mostly of older men. While accepting cultural attitudes there must be increased leadership opportunities for women and other skilled refugees to add their talent to the committees and to fairly represent their constituencies.
3. These workers will be valuable assets for Burma, but they will need to be certified in order to be accepted in future service roles. This requires a special initiative.
4. More information dissemination and training is needed about non-communicable disease, particularly mental health, gender-based violence, and chronic disease. Health workers may not be trained in these areas. Several conditions are recognized as inaccurately diagnosed or managed, and these are suitable for quality improvement attention. There is also a large variation among camps in the rate of patient referrals to other medical services. Assuming a similar case mix, there is a need to review procedures and to improve referral guidelines and decision-making.
5. Several camp activities are particularly effective and should be awarded recognition as Best Practices. These deserve to be disseminated so that others can adopt proven strategies. Examples include the surveillance and response information system, maternal and child health programs, and satellite clinic operations.
6. The Reproductive Health program should be expanded to cover Adolescent Health (important for young women) and post-abortion care, a major problem due to illicit abortion among migrant women.

7. Additional public information programs should be implemented to address residual areas of concern such as hygienic practices (e.g. use of latrines, vector control.)

Migrant programs

1. USAID should expand its support of migrant service activities within resource constraints. Activities within camps are exclusively dependent on donor funding, including USG funds, and should not be curtailed to allow expansion of services for migrants. USAID funding should only be reallocated to migrant services if current USAID funding for camp services can be picked up by State/PRM MRA funding, as is consistent with MRA and PRM mandates.

The camps have been denied income-generating capability. If funds were shifted from camp budgets to migrant/cross-border programs there would be negative operational and capacity-building consequences. The IRC budget does not have much flexibility. Besides camp funding (health, water, sanitation), it also supports Mai Tao Clinic, outreach programs, grants, and along with State/PRM, the Burmese Border Consortium the only source of food and relief supplies for all the camps. In the health sector the budget supports salaries, clinic operation, referrals, and trainers. There is little indication of other donors' readiness to replace reduced USAID funding. Staff salaries, camp departments and committees are paid from donor support.

2. Migrant service activities should initially target the Karen-Karenni-Shan border areas. Thai authorities have recently become more open to the idea, presenting an opportunity to increase migrant services in this area. The RTG is concerned about disease transmission. Also, registered NGOs working in the camp setting have excellent credibility in Thailand and good working relationships with local Thai officials.
3. *Beneficiary selection:* The migrant population is large, widely scattered, mobile, and challenging to reach. Several approaches are possible. HIV/AIDS organizations target "high risk" migrant males in coastal and large urban areas or at border "check points". Urban migrants are more likely than rural populations to find alternative means of access to medical care.

Some migrant groups and communities live in rural border provinces where there are established NGOs and ethnic CBOs. These are feasible target areas for migrant intervention. Experienced NGOs are available that should be able to expand migrant programs. Because the Thai government does not allow official refugee camps in Chiang Mai, all Shan are placed in a migrant status. There are several Shan NGOs that might be suitable to help implement migrant programs. To the extent possible, local Thai schools and clinics should also receive modest assistance with training and materials for public health activities. Help with training of all staff, and logistical support for vaccination campaigns could enhance Thai MoPH support of Burmese migrant assistance programs.

Among the issues relevant to beneficiary group selection on which fuller and more accurate information is required are the health characteristics and needs of migrant women and children.

4. *Planning and Development:* A coordinating mechanism should be established under CCSDPT auspices, to encourage donors and NGOs to exchange program information, coordinate planning, and present proposals to the Thai MOI.
5. *Delivery of Services:* Current experience with Migrant Health Projects (Appendix 7) suggests the importance of community participation and ethnic CHWs, working with an established NGO/CBO. A longer period may be needed to work out a joint program with the MoPH. Both approaches need further assessment. Mobile clinics staffed by Burmese and Thais, and available to remote populations regardless of national origin, should be emphasized. Where mobile clinics are not feasible, placement of TBAs for identification of maternal health needs and working with school teachers for identification of child health needs will provide initial information for purposes of appropriate intervention design.

We recommend that the mobile outreach program be matched to the community's needs and willingness to participate. The availability of resources and/or MoPH involvement will influence decisions about the model to use.

Cross-border humanitarian assistance (IDPs inside Burma)

1. Since USAID funding cannot be used to purchase non-US drugs, it should be allocated to acceptable components of these programs, such as staff salary support, training, supplies, logistics, and support of emergency care. Until a safe, sustainable repatriation can be undertaken, work with marginalized and needy IDPs is very important, because the various populations are mobile, and their public health conditions are linked.
2. Funding for cross-border Back Pack Medics and Karen state health programs should be increased to help very needy populations. Until a safe and sustainable repatriation can be undertaken, work with marginalized and needy IDPs is very important.
3. An assessment of experience in the Karen clinics and Back Pack Medic program should be done to give a preliminary profile of the state of infrastructure, including clinics, personnel, agriculture, and unmet health needs. This will be valuable for considering short- and longer-term objectives and targets.
4. Recent programs to train TBAs and teachers need to be assessed and revised if necessary. Because of the isolation of Back Pack workers and the lack of referral to Burmese hospitals, workers will need supplementary training in management of obstetric emergencies and injuries.

Coordination

1. Refugee programs, donor support and NGO partners have evolved over time. Interviews with five major donors and the UNHCR as part of this assessment found unanimous interest in "harmonizing" overall assessments and planning, with each retaining their unique regulations and priorities. They feel refugee programs are stable and effective. Migrant or cross-border (IDP) activities provide complex challenges that would be best served by well-coordinated programs. For example, the target populations are dispersed over large areas,

mobile, and apprehensive to seek outside assistance. Uncoordinated donor support may result in gaps in worthwhile programs or unnecessary duplications of effort.

2. Increased donor collaboration should start with exchanging information, priorities and plans. A more united donor group will enhance their refugee/migrant advocacy role and facilitate communications and the likelihood of support from the Ministry of the Interior (MOI). It is unclear what mechanism might be suitable for donor coordination. One option is to approach the CCSDPT to add a third sub-committee for Migrant Programs, as a trial forum for donor and NGO participation.

Conclusion

USAID has played an important role in helping NGOs achieve remarkable results in Burmese refugee camps, and such assistance has been essential to advancing US policy interests in the restoration of democratic government in Burma and in meeting the humanitarian needs of victims of the Burmese military junta. Some additions and refinements are recommended. Increased support for migrants and for cross-border health programs is timely and will help set the stage for eventual repatriation to Burma.

1. Introduction

For the past six years the U.S Government has provided funding to address the health and education needs of Burmese refugees and migrants living along the border between Thailand and Burma. These health programs, under the authority of the Thai Public Health Service, have provided basic medical care to Burmese refugees within and outside camps. The partner NGO programs have stressed Primary Health Care (preventive and curative) and training for service and management roles.

The current assessment is designed to help USAID plan a more systematic and long-term approach to health assistance for Burmese in the Thailand border area. It does not evaluate the current performance of individual NGO partners or grantees. It reviews the results of current refugee and migrant health programs and recommends future activities. This assessment includes USAID- and non-USAID funded humanitarian assistance to refugee camps along the Thai-Burma border, particularly the Karen and Karenni refugee camps. It includes food and relief supply distribution supported by the Department of State's Bureau of Population, Refugees and Migration (PMR). The Burmese migrant population (those not recognized as refugees and living outside the camps or in unregistered camps) in the border states was assessed as permissible by time and access constraints, but not the Burmese migrant population located in large urban areas.

The assessment team spent three weeks in Thailand (September 16-October 9 2004) to review the humanitarian aid activities of eight larger NGOs (18 people were interviewed), particularly International Rescue Committee (IRC), the American Rescue Committee (ARC) the Burma Border Consortium (BBC), and the education Consortium. All these organizations have extensive experience in Thailand and enjoy excellent reputations (appendix 4, 5). We also interviewed 20 people at 7 camps, clinics and satellite posts including staff, camp leaders and residents. We talked to 15 staff working under 5 donor organizations, and 6 people at 2 international groups (IOM, UNHCR)(See appendix 1).

Refugee Situation

Until 1984 Shan, Karenni, Karen and Mon and other indigenous ethnic nationalities controlled their traditional areas along the Thai-Burmese border as *de facto* autonomous states. They often crossed the 2400 km long border and ethnic groups lived on both sides. Then a series of dry season Burmese Army campaigns pushed the Karen National Union (KNU) forces back towards the border. In 1984 a massive Burmese offensive opposite Tak province drove 10,000 refugees into Thailand. Further losses of indigenous areas culminated in 80,000 refugees fleeing into Thailand by 1994 (BBC 2004). Inside Burma nearly 370,000 ethnic villagers have been forced to move to relocation sites. Another estimated 270,000 are IDPs (Internally Displaced Persons) in the eastern Burma areas living in temporary shelters or on the run from military forces (BBC 2002).

Most refugees entering Thailand camps were small family groups, often accompanied by friends. Until 1995 they could travel back and forth to procure food and shelter materials for use in camps. Subsequently, Thai regulations prohibited refugee travel, farming, or collecting firewood outside the camps (appendix 7). Income-generating work was not permitted and vocational

training by NGOs was curtailed. Not surprisingly, refugees are now completely dependent on outside help for food, shelter materials, cooking fuels, blankets and living supplies (BBC 2004). These restrictions have had adverse effects on self-sufficiency, camp morale and mental health, and long-term sustainability prospects.

In the Shan state near northern Thailand similar Burmese Army oppression, forcible relocations, and persecution have driven an estimated 300,000 across into Thailand. The Thai government permits no camps, so Shans are treated as illegal migrants. Because adult migrants are widely needed as seasonal labor in farms, orchards and factories, a recent one month period was opened to register healthy migrants for a one year Work Permit (appendix 7).

2. Situation Assessment

This section describes the findings for three groups (Burmese refugees and migrants in Thailand, and IDPs still in Burma along the border), and the level of coordination between NGOs and donors. Implications for future strategies and activities are discussed in the next section, entitled Conclusions and Recommendations.

2.1 Camp Refugees

The camp population is young with an equal gender distribution. About three quarters are Karen, and most others are Karenni. About 45% are below age 15 years. Less than 10% of households are single parent, and the number of unaccompanied minors is small. The camps are generally attractive and consist of traditional housing styles and a clean, well-maintained appearance. The surrounding terrain is hilly and forested, but road access is good, even in the rainy season.

2.1.1 Communicable diseases

The majority of patient problems are preventable infectious disease (appendix 6). For example, crowding (e.g. Tham Hin camp) is associated with respiratory infections, tuberculosis, and scabies; unsafe water or poor personal hygiene with diarrhea, typhoid fever, skin diseases; and mosquito transmission of malaria, dengue fever, and Japanese encephalitis (Appendix 6). Cases with leptospirosis, a rodent disease, may indicate a need to improve solid waste disposal. This disease pattern is the basis for relevant in-service training and community health education activities. Most diarrhea cases are mild-moderate with little severe dehydration. Health workers use standard treatment protocols found in the Burma Border Guidelines, a manual produced jointly by five NGOs. In addition there is a reliable drug and vaccine supply and safe storage and refrigeration.

Camp clinic staff maintains several disease surveillance bar graphs on clinic walls. These are visual monitors of the number of cases of malaria, diarrhea, and acute malnutrition each month. All were up to date. The staff watches these graphs to recognize above-expected number of cases, warning them of an outbreak. They recently stopped two outbreaks of dengue fever and malaria with mosquito spraying campaigns. Non-communicable diseases (injuries, mental health, violence) occur but are less common. Patient hospital referrals are done for labor complications, general surgery, tubal ligation, stroke, and cancer. When supervisors suspect over-diagnosis (e.g. "dysentery", "low birth weight", "beri beri"), they re-emphasize case definitions and give regular feedback.

2.1.2 Nutrition, reproductive health, and child health activities

Less than 4% of under-five children have acute malnutrition (PEM) (weight for height). Over 30% have chronic malnutrition (low height for age), suggesting inadequate calories in the past (appendix 6). The clinical diagnosis of Vitamin A deficiency (conjunctival Bitot's spots) has fallen with the introduction of Vitamin A supplements twice annually, covering 95% of camp children. B1/thiamine deficiency (dry beri beri) has also been diagnosed, but accurate assessment awaits definitive lab assays. Severe anemia in women is uncommon. A nutritionist for the Burma Border Consortium assessed Feeding Programs and the camp Food Ration for children and adults and recommended that total caloric content and fat/protein amounts be increased. Additional beans and fish paste were added to the staples to improve the diet. Preventable diseases for which there are vaccines are uncommon. There are few measles and no polio cases or neonatal tetanus. These results indicate that Reproductive/Child health programs are utilized and effective. Infant Mortality Rates, Child Mortality Rates and low birth weight rates are comparable to Thailand statistics, and far better than reported in Burma.

2.1.3 Management and capacity building

Satellite clinics with day care rooms are located at several camp locations to make services more convenient. There is an adequate number of health workers, and equal gender distribution, with an average of 25 patient visits per worker a day. Emergency services are available at all times. One camp is experimenting with a Counseling Room to allow women an opportunity for a private discussion. We observed that staff treat patients respectfully and clinics seemed remarkably quiet. The timeliness and accuracy of health statistics was generally good, blank registration forms were available, and facilities were clean and in good repair. We found an appropriate set of lab tests available, and technicians showed us correctly prepared malaria films. We were quite impressed at the scope of responsibility assumed by Karen and Karenni camp committees, ranging from control of food ration distribution with household ration books, to administering stipend payments to camp staff personnel, to a sub-committee charged with discussing village design and support needs when repatriation to Burma occurs.

2.1.4 Camp Environment, Water and Sanitation

Well-designed plastic and cement water containers, rainwater run off collection, and filtration provides safe drinking water. Over 60 liters per person per day is available year-round. Latrines are adequate in number and seem clean. But residents typically prefer to defecate away from latrines. (This suggests development of public information programs to encourage hygienic practices.). Camp maintenance staff can repair minor water and sanitation breakdowns. Due to Thai regulations forbidding residents to leave camps, all building materials and other supplies must be brought in from outside, creating an on-going dependency.

2.1.5 Grants for health related activities

The total grant allocation by IRC totaled \$2.7 million over a 5-year period. About one third of projects (32/85) were for health-related programs. Two thirds were expended for projects in Mae Sot, largely expenses arising from the Mai Tao Clinic, 19% in Mae Hong Son district, and another 15% for Bangkok and central area projects. In the camps, grants supported the Karenni Health Department, primary health care, health education, and equipment procurement and maintenance.

2.2 Migrants

About 150,000 persons presently live in nine refugee camps (BBC), and another 1.5 million or more Burmese are illegal migrants under Thai definitions. The Royal Thai Government (RTG) has complex feelings about migrants. Thailand and Burma have a long history of conflict. Current RTG policies condone migrant harassment, deportation and Anti-Drug roundups of migrants, who therefore hide or run. Burmese migrants often experience discrimination and hostility. The Thai definition of refugee is limited to “persons fleeing armed conflict”, much narrower than the international definition: “persons having a well-founded fear of persecution in their home country” (UNHCR). Thailand defines “displaced” Burmese as being either refugee or migrant. Yet in July 2004 there was a one month-long period when migrants could register for Work Permits.

Because health conditions in stable camps are quite good, donors are considering ways to expand services to assist Burmese migrants. “While needs in the camp continue, USAID anticipates shifting some efforts to address humanitarian needs of the growing population of Burmese refugees that live outside officially designated camps in Thailand. The challenge is how to identify and reach this growing external refugee population”. (USAID Burma Annual Report FY 2002) Planning a program for this population should consider several criteria, such as realistic target groups, migrant health needs and receptivity to help, the likelihood of MoPH cooperation, and feasibility issues such as availability of experienced NGOs, of outreach staff, and of transportation services. (see DFID Burma Country Plan, Feb. 5, 2004). Information is needed to answer several key questions, including: *Which migrant groups are most needy? What are their main health needs? How can basic primary care be made more available to them?*

The team was asked at USAID debriefings to comment on “any potentially adverse effects on camp programs if current financial support were shifted to new migrant programs.” This issue is also raised in the 2002 USAID Interim Burma Report.

The following are the salient considerations. The assessment has noted the inadvisability of reducing financial support for camp populations, and has suggested finding alternative sources of funding if there is a perceived need to shift USAID funding to migrant programs. USAID is the major donor for health programs in Karen and Karenni refugee camps, and since the camps lack any income-generating capability, they are completely dependent on donor support, which in the case of the US consists of a combination of USAID and State/PRM funding. The estimated 150,000 camp refugees are unlikely to be reduced in numbers given the uncertainty of repatriation or willingness to return. Indeed, USAID indicated that it anticipates refugee funding at least at current (or higher) levels for some years. If additional funds for migrant programs do not materialize from any quarter, and if there were a determination to transfer resources to migrant programs, we could only recommend a very gradual phased reallocation to minimize abrupt program changes, and to allow careful design of migrant programs, including identification of appropriate target groups, and establishment of rapport with and support to CBOs.

2.2.1 Target group selection

Which migrant groups need health care the most? An outreach program cannot reach all migrants. Migrants vary considerably in age and gender groupings, locations, and access to care.

A priority target should be the most vulnerable or disadvantaged subgroups. The Global Fund and other donors already support a system of bilateral border screening programs to deal with malaria, tuberculosis and HIV. Young migrant males and fisherman are at higher risks of STD/HIV, with some fishermen surveys showing HIV rates above 7%. There have been recent talks about implementing Migrant Worker Drop-in Centers (appendix 7).

2.2.2 Health needs

New migrants become sick with the endemic diseases prevalent in rural Burma: malaria, dengue fever, respiratory infections, skin disorders, with high IMR and CMR (appendix 6). Reports from a Karen state clinic confirm malaria's dominance, with severe anemia the major reason for hospital referrals (IRC). Women suffer from complications of illegal abortions (Belton). Some ill migrants even cross back into Burma for treatment by traditional practitioners. Migrant preventive services are deficient with low vaccination rates. Most Shan women deliver their babies by traditional birth attendants (Meng).

2.2.3 Receptivity

Migrants are a heterogeneous group with differing health needs, resources and willingness to enter health care. Some flee from repression or violence but are not allowed to enter camps for asylum. Many others are economic migrants who travel long distances to find various kinds of work. Typically they are young people with little education or vocational skills. They seek work in farming, fishing, factory jobs, or at unskilled labor. Often women migrants hope to return to Burma "in a few years" if they can save enough to start a business. However, they rarely save since wages are so low (World Vision, 2004). Some migrate to urban areas for construction work; others go to coastal areas to fish. About a third, chiefly from border areas, bring children with them who may attend school only a year or two before starting to work. Over 200,000 Shan migrants live in Chiang Mai and Chiang Rai provinces, with one thousand new migrants entering Fang District, Chiang Mai province each month. Health information about Shan migrants is unavailable due to their poor access to health care. There are no camp-based statistics as in Karen and Karenni camp, although infections and malnutrition can be assumed. There is a need for better baseline information about the health needs of Shan.

Pilot studies have provided important lessons for migrant outreach efforts (appendix 7):

It is critical to gain the migrant community's trust to have any success. Where pilot programs had limited CBO, community involvement or use of ethnic CHWs, attendance was disappointing. When health workers are scarce it is important to train local people to help. Established NGOs with ethnic staff and long-standing ties to a migrant community will attract participation.

2.2.4 Migrant outreach options

Several NGOs have developed good referral networks (e.g. Mai Tao Clinic in Mao Sot; Jesuit Refugee Services in Chiang Mai). They refer seriously ill migrants to hospitals for obstetric complications, surgery, injuries, or other problems. While the Thai health system accepts non-Thai patients who can pay, access is difficult due to discrimination, language barriers, fear of hospitals, and costs. Few seasonal workers can afford to purchase a Thai health insurance card that costs 2-3 months' wages. Furthermore, in rural areas, MoPH clinics are often closed. As a result few migrants receive Maternal and Child Health services or health education. Language

and cultural barriers make it important to obtain community support for a mobile visit program. Migrant outreach options include:

Participants	Facility/Staff	Comments
Community based	Local teacher. TBA Volunteers.	May be feasible. Inexpensive. Modest skill levels. Need on-going training, support.
MoPH only	Clinical services	Valuable for emergency care. Barriers include language, access, attitudes towards migrants.
NGO only	Mobile team unit	Can be effective if community supports. Important to include ethnic CHWs on staff.
NGO + MoPH	Static clinic + outreach activity	Valuable complementary approach. Try to overcome barriers with training, translators.

It is also important to try to involve the Thai MoPH. Often local authorities will be supportive, particularly if Thai residents are included in the target group. The MoPH is under-resourced in ways that must be mitigated to encourage it to expand services to Burmese migrants. (Appendix 7)

Little information is being exchanged between the NGOs and sponsoring donors that work in migrant programs. A coordination mechanism similar to that used in the CCSDPT for refugee programs could help in planning migrant health services.

2.2.5 Grants for health related activities

The total grant allocation by IRC totaled \$2.7 million over a 5-year period. About one third of projects (32/85) were for health-related programs. Two thirds were expended for projects in Mae Sot, largely those arising from the Mai Tao Clinic, 19% in Mae Hong Son district, and another 15% for Bangkok and central area projects. For the migrant population, the grants program developed several water and sanitation projects for migrant villages. Other grants helped the Shloko Malaria Research Unit (SMRU) in Tak Province carry out health education and another helped the Factory Workers Health Unit.

2.3 Cross-border humanitarian programs (IDPs)

The initial phase of refugee repatriation to Burmese border states (Mon, Karen, Karenni, Shan) will probably focus on the “crisis zone” adjacent to the border. Hazards include extensive infrastructure destruction, scattering of residents, and landmines in many areas. Many IDPs are in hiding and lack adequate food or medical care. There is a high prevalence of communicable diseases and malnutrition (40% of under-fives). HIV has spread to the general population with a reported 2.2% HIV rate among pregnant women. These conditions and the lack of medical care culminate in an under-five mortality rate of 109, and a maternal mortality rate of 230 (World Bank, UNDP 2003).

2.3.1 Joint Action Plan (JAP) for Myanmar-Thailand Health Collaboration at the Border Areas

The overall goal of this MoPH-Burma border program, started in 2000, is to improve outcomes in malaria, tuberculosis, and HIV/AIDS incidence. About 20 teams are used for health education and program operations. The plan includes surveillance activities, cross-border control activities, malaria clinics, STD syndromic management, and condom distribution among 16

Burmese townships along the border. It is unclear if these vertical programs might be expanded to include R/CH activities to women and children in the area or collaborate with other migrant programs run by NGOs. Results of several JAP studies are available:

- 1) Malaria. 42% of about 82,000 confirmed cases (2002) were non-Thais, usually from heavily forested border areas where vector control is ineffective.
- 2) Tuberculosis. The National TB Program estimated about 900 cases were non-Thais out of 100,000 new TB cases in 1999, which is under 1% of all diagnosed cases.
- 3) STD/HIV. MoPH statistics indicate peak Thai HIV rates in the 25-34 year old age groups for both genders, with males outnumbering females 2-3 times (2003). No similar information was found for migrants.

2.3.2 Backpack medic teams

Two outreach Back Pack Medic Team programs from the Mai Tao Clinic have operated 70 teams for the past 5 years. Each team is composed of 3-4 workers, and is assigned to a target population of about 2000 in Karen, Karenni, and Mon States. Two health clinics recently started in northern Karen state had 25,248 visits in 2003. A referral hospital is 6 hours away and supplies, medicine and some food must be brought in from outside. Two new backpack medic teams have started going into Shan state. These programs offer models for future expansion. Information being collected by these workers is a valuable resource for planning of health services for populations in Burma. More systematic collection and analysis of such data is the essential precondition for the design of appropriate services of a cross-border kind.

2.3.3 Grants for health related activities

The total grant allocation by IRC totaled \$2.7 million over a 5-year period. About one third of projects (32/85) were for health-related programs. Two thirds were expended for projects in Mae Sot, largely those arising from the Mai Tao Clinic, 19% in Mae Hong Son district, and another 15% for Bangkok and central area projects. Grants support training and cross-border outreach programs at the Mai Tao Clinic. A two-year block grant of \$500,000 funded the Pha Hite Clinic and a second smaller clinic, La Per Heh, in northern Karenni state. A series of one-year grants were awarded to support the Back Pack Medic programs. Other grants support IDP public education, water and sanitation, personnel stipends, and supplies.

2.4 Coordination

There is a high level of cooperation (see appendix 8) among members of the CCSDPT (appendix 5) with well-attended monthly meetings and information sharing. CCSDPT sub-committees undertake important reviews and working groups address general issues. Members submit proposals and prospective Work Plans through the CCSDPT to the MOI. In contrast to these NGOs, the level of cooperation among the half dozen key donors is modest. Recommendations to improve donor cooperation are given below. It is also recommended that USAID's leverage as a donor should be exercised, and resources provided to support establishment of implementer coordination mechanisms for services to non-camp migrants and for cross-border programs.

2.5 Repatriation – Contingency Plans

Given the low likelihood of political developments in Burma that would provide security to those who have fled the country or have been displaced within it, repatriation of Burmese from Thailand is not a viable option. This uncertainty about the future has only been compounded by recent political developments in Burma and in its neighbors' policies towards Burma. No timeline has been established for repatriation, nor should one be under current conditions. Nonetheless, there is recognition among donors of the integral relationship between work in Thailand and Burma, and the high vulnerability of marginalized ethnic minorities along the Burma-Thailand border. In addition to USAID's indirect support for cross-border activities, other donors help several agencies currently working in Burma. These include AMI, MSF, World Vision, CARE and ICRC (health, food, water, sanitation) with support from Japan, DFID and AusAID.

In September 2004 the UNHCR asked NGOs in the CCSDPT to help draft preliminary contingency plans for eventual refugee repatriation to Burma. A draft is expected imminently. The UNHCR also reports that it has been asked by the Burmese government to help coordinate NGOs in Burma. Without suggesting any qualification of the imperative to resist immediate moves to repatriation, it is clear that programs designed to improve humanitarian conditions on both sides of a porous border between inter-connected regions, as described above, constitute a simultaneous preparation for eventual repatriation were it to occur. Among the common criteria to be borne in mind are: capacity building among refugee groups most likely to return, training in conflict resolution and reconciliation, and estimated start-up resources needed.

If and when repatriation occurs, sustainability issues will include elements such as work opportunities and skills (camp vocational training), local leadership (camp management capability and committee roles), availability of school and health resources (camp training and experience in these roles, and certification to be eligible to practice in Burma), current health needs among Burma IDPs (reports by Back Pack Medics doing cross-border health programs) and other issues beyond the scope of this assessment, such as security, location, and land mine clearance.

The BBC 2003 Annual Report summarized the policy and program planning issues as follows: "Although none of the major stakeholders see Repatriation being possible in the near future, this is an opportunity to document the many factors which need to be taken into account, and, most importantly, to get the views of the refugees themselves." Interviews with DFID, ECHO and AusAid indicated an interest in further discussion along these lines.

1. Lack of information. Restricted access and ongoing fighting make current population information incomplete. Available information from small-scale cross-border assistance programs (see Cross-border regarding emergency food and medical assistance) corroborates a high prevalence of communicable diseases and malnutrition (40% of under-fives). Endemic conditions and the lack of medical care culminate in an under five MR of 109, and a MMR of 230 (World Bank, UNDP 2003).
2. Infrastructure breakdown. The ruling Burmese junta has little interest in needs of residents of border areas. The government is isolated from pressure by either the

international community or from repressed democratic opposition groups in Burma, such as the NLD. It may be assumed that physical facilities are badly deteriorated, lack equipment and supplies, and have few health workers able to perform effectively. Information should be gathered with rapid assessment methods include a mapping exercise in the immediate border areas to help link needs to geographic areas. The analysis could describe population distribution, health facilities, roads, water and sanitation systems, and landmine restricted areas. Some “assessments” were reportedly completed, but we could not find the results.

3. Refugee intention to return to Burma. Even refugees who long to return to Burma may adopt a wait-and-see attitude. They will want to be assured of adequate security for returnees. *Will there be on-going support and assistance until they can rebuild homes and become self-supporting in agricultural and other vocations? What are their prospects for adequate schooling and medical care?*

3. Conclusions and Recommendations

This section includes key findings and conclusions as the basis for recommending future activities or offering options when information is incomplete or a situation is evolving.

3.1 Camp Refugee health programs

1. Camps have achieved remarkable improvements in communicable diseases, malnutrition, and mortality rates of children and mothers. These results are due to relevant clinical services, staff use of treatment protocols (Burma Border Guidelines), and high target group coverage with vaccination programs, antenatal care, and deliveries by trained attendants. Support services in training, drug supply, lab services, information, and staff numbers are excellent. Health hazards have been addressed with good water, sanitation programs, providing mosquito nets, mosquito spraying, and monitored distribution of household food rations. The Camp Committees and Departments have important administration tasks due to IRC “transferring” its initial management roles.
2. Grants have been a valuable stimulus and resource to enable talented individuals and CBOs to identify health needs and work out interventions. Examples range from safer stoves, model gardens, and development of treatment manuals to migrant health projects and cross-border medic outreach. These activities engage refugees in solving problems and planning for the future.
3. Camp residents remain completely dependent on humanitarian assistance for their food, bed nets, blankets, building materials and other relief items. Thai policy precludes income generating training or providing a small land area for growing crops and helping the food security gap. The BBC has an effective procurement system and collaborates with the camp CBO in controlled distribution of food rations. Rising commodity prices may require additional funding support. Donors should jointly challenge current RTG policies that hinder refugee programs and promote changes that help refugee self-sufficiency and competence for eventual repatriation.

Recommendations

1. Continue with current programs at current levels.
2. Proven activities and procedures should be sought and recognized as Best Practices and disseminated to help standardize effective programs. A non-remunerative program to award Outstanding Performance or Excellence in Service should be initiated with certificates or an annual Recognition Dinner. The Health Messenger provides a channel for disseminating recommended approaches and information updates.
3. Qualified staff with necessary training and experience should be considered for a certification process. This would include medics, other health personnel, and several managerial posts. The number of health workers in Kerenni, Karen, Mon and Shan states are low and that additional workers would be useful. Several steps have been proposed:
 - a. Review any Health Worker position regulations in Burma for information about specific titles and to indicate how camp curricula and study are related to Burmese rules. Apparently the Burmese Medical Association was consulted in 2001 to help design the Health Assistant Program.
 - b. UNHCR may be an important intermediary and advocate for proactive certification.
 - c. Ask UNCHR/WHO to request authorization from Burma to document courses of study and training received by refugees in camp programs; or
 - d. Contract an external education institute to validate a training course.
4. Additional recommendations as described in the narrative above include acquiring better information about diagnoses of trauma, GBV, chronic disease, and mental illness. A Quality Improvement capability should be established so that local staff identify and address operational or clinical issues. One example is to undertake a review of referral criteria, rates and outcomes, because of a wide variation in camp referral rates.
5. In this stable camp refugee phase, expatriate physicians and coordinators may be short-term, with a higher turnover and gaps between filling positions. A standardized orientation procedure (e.g. refugee needs, roles in training and supervision) would be valuable.

3.2 Migrants

Migrants live in border, coastal and urban locations of Thailand. With Burma's poor health care, migrants have endemic diseases that are vaccine-preventable or related to poor living conditions and inadequate food. Additionally, workers experience injuries and toxic exposure such as sprayed pesticides in commercial farm work. Those located in border areas have the least opportunity for jobs that pay enough to make paid healthcare affordable, and even Thai health care resources are scarce in the same border areas. Coastal migrants, particularly male workers, are targeted for government screening programs to reduce HIV and tuberculosis transmission. Urban migrants may find healthcare theoretically available closer at hand, though their access to it is uncertain. Perhaps urgent care will be more readily available to them. On the other hand, a cost benefit analysis may suggest higher yield for the money in concentrated urban populations than in scattered and inaccessible rural ones. Female migrants cannot obtain reproductive services. Often employers discharge pregnant women workers, resulting in many illicit abortions with complications (Belton).

Effective migrant health programs will need to include well designed Reproductive/Child Health services, injury management, and support of referral systems to Thai facilities for serious conditions. The 150,000 Shan migrants in northern Thailand face major constraints regarding access, as they move about and try to avoid Thai deportation. They lack the humanitarian resources that western provinces with refugee camps and modest outreach programs have achieved. The network of NGOs/CBOs working among Shans should receive increased support and helped to coordinate and integrate their programs.

Options

For these problems, basic Primary Health Care services are a priority. To gain migrant cooperation with outreach programs, NGOs develop ties to the migrant community and work through their leadership, including women. Several questions are important:

In such a large and diverse migrant population, who should be targeted?

Given their mobility and fear of authorities, how can they be reached?

If camp funding is shifted to support migrants, are there negative consequences?

3.2.1 Target population

The prime target group should be children and women located in rural border areas, particularly Karen, Karenni, and Shan. Some migrant women and children who work in border factories may be accessible, with factory management approval. An example of this approach is a Factory Workers Health Unit in Mai Sot supported by a USAID grant. Other donors, including WHO, Global Fund, and the Thai MoPH, have all begun programs to control malaria, Tb and HIV transmission with various migrant groups. However, there is little coordination between these activities.

3.2.2 Options for migrant health program design

The overarching criteria should be feasibility for the setting and acceptability to the community.

Is there an experienced NGO/CBO in that area, that can identify potential sites and has credibility and trust in the target community? The Karen and Karenni camps have benefited from well-established NGOs, supported by the CCSDPT. In Chiang Mai and Chiang Rai, a modest level of health activities is being done with NGO/CBO assistance. If and when migrant health programs expand in this region, successful program experience in Mai Hong Son and Mai Sot should be shared.

The migrant community attributes are important. Is the community large enough to justify the use of a mobile clinic? Is there leadership that can mobilize intended beneficiaries? Will the community agree to some kind of "matching", such as providing a visit site and/or volunteers to help at registration and with education activities? If necessary, will migrants pay a token fee for health care or a set of vaccinations for a child? Any co-payment option needs adequate discussion with stakeholders so it is not a barrier. Since a mobile program has limited resources, these considerations help it be cost/effective. An interim strategy might be to train local TBAs and teachers. (See Table below)

Will the MoPH help? Can local Thai children and women also be included? Inclusion might be one way to involve the MoPH in annual vaccination campaigns or health education activities, if not more frequently.

These factors may be displayed in a criteria matrix to consider outreach care options.

NGO – CBO Available?	Community Receptive?	Mobile Unit Available?	MoPH Supportive?	Possible Outreach Model
Yes	+	+	Yes	NGO-MoPH-community
Yes	+	+	Uncertain	NGO-community
Yes	+	No	Uncertain	Train teachers, TBAs
Yes/No	No	No	No	Not a program candidate

3.2.3 Migrant Health Program – Proposed activities for short and long-term objectives

Successful migrant programs in Tak province and in Mai Hong Son (Appendix 7) have shown the importance of making time to gain community support and participation and using indigenous health workers who understand and want to serve migrants. Once a district migrant health program is established, it can be expanded to adjacent districts and try to include nearby Thai residents. While experienced NGOs are important, grant help should be available to encourage the development of CBOs to manage migrant programs and to increase community participation. If funds must be reallocated from current camp programs to support an expanded migrant outreach, careful planning with camp NGOs and CBOs should improve decisions and allow time for budget and program adjustments. However, we do not recommend such a reallocation, since camp programs are effective. Migrant programs would be justified as additional measures to address serious needs and promote US policy interests, but on a per beneficiary cost basis entail start-up costs and higher costs arising from distance and cultural issues in reaching target populations.

Proposed Activities	Years 1 and 2	Years 3 and 4	Year 5+
I Donor migrant collaboration. Initial NGO-CBO activities.	----- Familiar areas	----- Expand areas	-----→ Upscale
II Encourage additional CBOs. MoPH participation and support.	Grant support. As willing, able.	New areas -----	Expand -----→
III Increase access to Thai health care. Address barriers to utilization.	Advocacy. Public education	Policy change Translators	RHC, etc Logistics

3.3 Cross-border Programs (Burmese IDPs)

There is over five years' experience in delivery of core Primary Health Care services in Mon, Karen and Karenni states through 70 Back Pack Health Worker Teams and more recently by programs based in two Health Centers supported by the Mai Tao Clinic system. These visionary outreaches to a very needy populations are based on careful selection and training of medics and health workers. They return at 6-month intervals for re-training and supply replenishment. The program makes longer-term plans with the support of 2-year block grants. Statistics indicate a large number of visits, the establishment of water-sanitation projects, and early School Education and TBA training initiatives. Because of the cross-border health

workers' wide geographic distribution and experience caring for patients, these programs offer a potential description of Burmese health needs.

Options

1. A review of experience at the clinics and in the Back Pack program is recommended to compare patient needs with current training and supply resources. Of additional interest would be the assessment by these personnel of unmet needs and areas to be considered for additional resources.
2. After 5 years of experience, it is possible to assess the relative emphasis to be given to, and the sequencing between consolidation of current work at present locations and its expansion into new areas. Consolidation implies effort to continue the best practices and consider how to improve curative care. It is also now possible to assess the effectiveness of Reproductive-Child Health programs, School Education, and TBA training.
3. The hospital referral rates are very low for the patient volume. Although logistics, border restrictions, or patient reluctance may be factors, an analysis of the causes and possible solutions should be considered.
4. There may be opportunities to work with UNICEF (e.g. vaccinations, feeding centers) and UNHCR to assess border region needs and to identify operational clinics and schools, land mine areas, location of villages and towns in order to determine the need for/obtain additional program resources.

3.4 Coordination

3.4.1 NGOs

As noted above, the CCSDPT provides a forum for discussions and plans, helps to generate useful materials, and provides an effective advocate to the MOI.

1. A more structured Clearinghouse function is recommended for the CCSDPT, with soliciting local Best Practices or Valuable Helps during monthly meetings. This would also advertise scheduled training opportunities, available materials, resource persons, or other features. Those that attract wide interest might be set up as a workshop.
2. If migrant and cross-border programs are significantly expanded, the CCSDPT should be supported in redefining its role and functions. In 2003 the IRC started to re-train its medics and reproductive/child health workers "beyond" curative care to enhance their capacity in prevention and health promotion. A scaling up of this should be supported, beginning with a review and discussion of this effort and experience among other camp-based NGO/CBOs. Systematic review and discussion would also provide design guidance to the incipient migrant and cross-border initiatives.
3. The CCSDPT should be encouraged to establish a working group for Migrant programs, bringing together a select group of those involved in its Education and Health Sub-committees. This working group would provide some of the same exchange and sharing opportunities as other. The Migrant group should help review experience from the Migrant Health Projects (USAID, ECHO) as well as MoPH policies affecting these initiatives. The

working group for Migrant programs could either be expanded to also cover cross-border program development or be supplemented by a similar group for cross-border programs.

4. If NGOs/CBOs express interest, the CCSDPT could sponsor a workshop about migrant program design and management. This could include USAID expectations for implementation reports, use of monitoring and evaluation, and the likelihood of smaller numbers of beneficiaries than reported for camps.

3.4.2 Options to help donors coordinate plans

As noted above, donors are more interested now in effecting ongoing coordination than in the past. Among the activities that would help realize shared donor aspirations are the following.

1. Consider a survey of donors' current "country plans" and program support, perhaps organized under UNHCR auspices, to initiate an exchange. Newer issues, such as unmet needs, recent program experience, or areas where collaboration is sought would be valuable. A meeting to consider collaboration should be initiated.
2. Support for conducting a border area Needs Assessment, noted under Cross-border above, should be of general interest. Donors may have specific areas or sectors they want information about or proposals to be discussed.
3. If not already done, invite the donors to an annual CCSDPT meeting such as Implementation Plan or "The Way Forward" to stimulate further collaboration.

3.5 Repatriation – Contingency Plans

1. Given the low likelihood of political developments in Burma that would provide security to those who have fled the country or been displaced within it, repatriation of Burmese from Thailand is not a viable option. This uncertainty about the future has been compounded by recent political developments in Burma and in its neighbors' policies toward Burma. No timeline has been established for repatriation, nor should one be under current conditions. Nonetheless, there is recognition among donors of the integral relationship between work in Thailand and Burma, and the high vulnerability of marginalized ethnic minorities along the Burma-Thailand border. Thus, preparation for a remote repatriation offers opportunity for capacity building among refugee and migrant communities, as well as providing arguments to persuade RTG to permit certain types of vocational training for Burmese in anticipation of repatriation and to make it enduring.
The initial efforts should start on a modest scale in areas where reasonably good data exist. Programs should target community development, essential health and education services, and food security. A participatory approach with community leaders, CBOs and ethnic authorities is required to help people learn to tackle their own problems during the developmental phase.
2. A long-term work plan, objectives, and strategies with adequate funding helps NGOs to better plan medium and long-term strategies. At the same time, donors need assurance that inputs are appropriately used in monitoring implementation. Fortunately, current NGOs working in Burmese refugee camps have proven their competence in crisis interventions,

capacity building and longer-term development. It would be prudent to start programs at border areas close to refugee/migrant programs in Thailand. Then, in the mid-term phase, interventions found to be successful could be expanded. Caution may be in order about the extent to which the perceived security concerns of RTG might prevent its agreement to such initiatives.

3. Thai government support of migrant /IDP programs may be promoted by noting that addressing basic needs and poverty now will enhance future development of a more stable Burma, and encouraging RTG to look beyond fears of cross-border transmission of HIV/AIDS. Successful repatriation is critical for Thailand itself, since a restored and peaceful Burma may reduce the numbers of “migrants” seeking a safer life. A major sustainability factor will be returnees’ income-generating ability. These long-term issues may help change RTG policy regarding vocation training in camp settings.

Conclusion

USAID has played an important role in helping NGOs achieve a remarkable result in Burmese refugee camps, and should continue to do so. The addition of increased support for migrants and, as feasible for cross-border health programs, is recommended.

Appendix 1: Persons Interviewed

Non-Government Organizations	
AMI	Aide Medicine Internationale (camp health services) Administration, Mae Sot program
ARC	American Refugee Committee International (services; WASAN; development) Gary Dahl, SE Asia representative; Thailand director
BBC	Burma Border Consortium (food, shelter, supplies; coordination of NGOs) Jack Dunford, Executive Director, Bangkok Sally Thompson, Deputy director, Bangkok (01 905 7488) Lah Say Sawwah, Coordinator, Mae Hong Son
BRC	Burma Relief Center (Shan migrants) Chiang Mai Pippa Curwen, Coordinator, Chiang Mai (01 783 2830)
CCSDPT	Committee for Coordination Services Displaced Persons in Thailand
Consortium	Mae Sot Tak province (Education: camp schools; teacher and principal) training; technical assistance; camp committee capacity building) Fred Ligon, director (01 844 8096) Delilah Borja, deputy director Greg Antos, education specialist Suwannee Neramitpanit, field coordinator
Handicap International	(Train prosthetists; provide prosthetics) Coordinator, Mai Sot
IRC	International Rescue Committee (camp services; training; grants) Michael Alexander, Acting Director, Bangkok Cate Breen, Acting Deputy Director IRC (Out-of-Camp Health Program) Mao Tao Clinic Dr. Cynthia Muang, Mae Sot Khun Somsak, Field Coordinator, Mae Sot Michelle Pereira Field Coordinator, Mae Hong Son Heidi, Gender Based Violence program Tracy, Reproductive Health program
In-Camps and Out-of-Camp Migrants	
Mae La Camp	Tha Song Yang District, Tak Province MSF, Outpatient Physician
Umpiem Camp, Tak Province	Outpatient Medic (xxx) Water and Sanitation Coordinator
Mai Tao Clinic, Mai Sot Tak Province	Dr. Cynthia Muang, Director Khun Somsak, Field Coordinator
Phop Pra District Migrant Health Project (ICR)	Michelle Pereira, Field Coordinator and staff
Tak Migrant Health Project (IOM)	Rattana Kreuthai, IOM Field Coordinator, Mae Sot Somsak Thanaborikon, Coordinator
Karenni Site 1, Hong Mao Son Province Ben Tractor Clinic and satellite	Sompura Mala, Health Information System Camp Karenni, Repatriation Subcommittee (6 members) Alexander, Karenni Refugee Committee, Secretary Mr. Wajiri, RTG Camp Commander

International Organizations	
IOM	International Organization for Migration (Out-of-Camp/Migrant Health Program) Irena Vojackova-Sollorano, Chief of Mission, Bangkok Jaime Calderon, Project Coordinator, Bangkok Rattana Kreuthai, IOM Field Coordinator, Mae Sot Somsak Thanaborikon, Coordinator, Mae Sot (Migrant Health Project, health posts, liaison with MoPH)
UNHCR	Hanne Marie Mathisen, Head Field Office Mae Hong Son Province Bernard E H Quah, Assistant Regional Representative (Operations) (Thailand, Laos, Cambodia, Vietnam) Bangkok
Donors	
AusAid	Australian Agency for International Development, Bangkok (IDP Care) Bronwyn Robbins, First Secretary Sutthana Vichitrananda, Project Manager
DFID	South East Asia, Phillip Marker, Program Manager, Bangkok
European Commission	Andreas List, First Counselor, Bangkok (ECHO camp health care)
U. S. Embassy Bangkok	Timothy Scherer, State Department, Labor Affairs and Anti-Trafficking
USAID Regional Development Mission/Asia (camps, migrants, cross-border)	E. E. Skip Kissinger, Acting Director Matthew Friedman, Deputy Director Regional HIV/AIDS Michael Stievater, Office of General Development Pandita Schaedla (Jib), Coordinator
USAID/Washington DC , Office of East Asia affairs	Christine Wegman, Asia/Near East Bureau Kay J. Freeman, Deputy Director, Office of E. Asia Affairs Patty Chaplain
Bureau Population Refugees and Migration	Kathy Gelner, Washington DC Michael Hannold, Refugee Coordinator for SE Asia, Bangkok

Appendix 2: Documents Reviewed

Stakeholders

BBC Burmese Border Consortium Report Jan-June 2004

Burmese Border Guidelines. 2003 Funded by USAID through IRC (medical care)

CCSDPT Annual health statistical report. Thai-Myanmar Border, 2002 April 2003

DFID Burma Country Plan. Draft February 5, 2004

IOM/MoPH Migrant Health Project 2004-2005. Tak Province.

IRC Major Project Review. Dec 1 1998-March 31 2005 (AEP-G-00-99-00028-00)

Mao Tao Clinic 2003 Annual report. September 2004

Ministry of Public Health. RTG Several reports about malaria, tuberculosis, STD/HIV.

MoPH January 2000 Thailand Health Profiles 1997-1998 Chapter 7 Major health programs and activities implemented

MSI Technical proposal for USAID/Regional Development Mission Asia to review the Thailand/Burma health and education activities. August 2004

UNHCR Country Operations Plan for Thailand, 2004. Regional office, Thailand

UNHCR Practical guide to the systematic use of standards and indicators in UNHCR operations. 2004

USAID Scope of Work to review the Thailand/Burma health and education activities and to develop comprehensive RFA(s) for these sectors. July 2004

USAID Burma. Annual Report FY 2002. Results Information

USAID Burma Interim Program Review. June, 2002. Assessment of the Thai/Burmese border humanitarian assistance programs (IRC, World Learning)

Background

Asian Research Center for Migration. Chulalongkorn University, Bangkok 2004

Running the gauntlet. The impact of internal displacement in southern Shan State.

Belton S, Maung C Fertility and abortion: Burmese women's health on the Thai-Burma border.

Belton S Post abortion care: Who cares? Health Messenger March 2003, pp 46-53

Bradt DA, Drummond CM Rapid epidemiological assessment of health status in displaced populations. An evolution toward standardized minimum, essential data sets (MEDS). Prehospital & Disaster Medicine 2002; 17(4): 178-85

Sphere Project. The Sphere Handbook. 2004 revised edition. Chapter 5. Standards in Health Services, pp 250-310.

Toole MJ, Waldman RJ JAMA 6/27/90; 263(24):3296-3302 Prevention of excess mortality in refugee and displaced populations in developing countries

UNHCR Project planning in UNHCR. A practical guideline on the use of objectives, outputs, and indicators. 2nd version. 2002.

UNHCR Handbook for Emergencies. Chapter 14 Health. Pp 154-183.

USAID Evaluation Highlights No. 73 Complex emergencies and USAID's humanitarian response. CDIE/USAID. Washington. July 2001

USAID. Foreign Disaster Assistance. Field Operations Guide Version 2.0

U.S. Committee for Refugees. World refugee survey 2004, Thailand. May 2004.

Van Brabant K Opening the black box. An outline of a framework to understand, promote, and evaluate humanitarian coordination. June 1999. Humanitarian Policy Group. Overseas Development Institute. London.

Appendix 3: Draft RFA

USAID has supported education and health programs for 3 groups: Burmese refugees living in Thai camps, migrants located outside camps in Thailand, and internally displaced persons (IDPs) in Mon, Karen, Karenni and Shan states in Burma. These groups vary markedly in their health needs, living environments, and access to basic services. NGOs have developed effective camp programs with reduced communicable diseases, malnutrition, and mortality rates. The camp system needs to sustain these accomplishments and to standardize procedures for patient care, management information systems, monitoring and evaluation, and the sub-grants program. Smaller NGOs often lack expertise in these functional areas and they will need on-going technical support from the main contractor working with the CCSDPT.

The migrant and cross-border programs are less developed. The large and growing migrant population is not as easy to identify and reach. Cross-border programs vary from the donor-supported Back Pack Medic project in Karen and Karenni states to a Thai government program limited to screening migrant workers for HIV/Tuberculosis and malaria. Outreach programs need to first establish rapport with target groups and community leadership, then to gather baseline data about client needs and to establish “realistic” implementation targets, and finally to adjust service activities over time. This report describes several program elements and related activities for each target group.

REFUGEE CAMP ACTIVITIES

1. Continuation of Current Activities, and Improved Access to Appropriate Primary Health Care Services

- a. Provide appropriate patient care and referral services
- b. Maintain effective RCH and other preventive services
- c. Establish comprehensive EPI and nutrition services
- d. Provide health education to address common refugee problems
- e. Locate satellite clinics to facilitate use by women and children
- f. Scale up IRC program to re-train medics and RCH workers to move beyond curative care to enhance capacity as prevention and health promotion educators/monitors
- g. Systematic monitoring and evaluation

2. Strengthen Clinic Management Capability

- a. Establish on-going pre-service and in-service staff/supervisor training with consideration of training certification for potential work in Burma
- b. Strengthen information system for surveillance reports, monitoring drugs and supplies, and the monitoring/evaluation function
- c. Standardize job descriptions, treatment and referral protocols, report procedures
- d. Monitor and evaluate worker and supervisor compliance with guidelines
- e. Establish maintenance and repair schedule for facility, equipment and vehicles
- f. Identify outstanding performance for recognition and dissemination to NGOs
- g. Identify service deficiencies for staff problem-solving effort
- h. Systematic monitoring and evaluation.

3. Improve Camp Living Environment and Reduce Health Hazards

- a. Establish and maintain water, sanitation, and solid waste disposal systems

- b. Procure, distribute and monitor equitable use of food rations, blankets, nets, fuel, and shelter materials
 - c. Establish surveillance information to guide activities for pest and vector control
 - d. Public education and information campaigns on hygiene and sanitation
 - e. Systematic monitoring and evaluation
4. Strengthen Camp Leadership Capability
- a. Support camp committees and departments in their development and functions
 - b. Continue sub-grant program activities to support camp leadership and Community Based Organizations
 - c. Identify motivated health workers and staff personnel for training and work opportunities, particularly younger individuals and women
 - d. Seek opportunities to improve camp functions and address longer term issues, such as vocational training and repatriation to Burma
 - e. Systematic monitoring and evaluation.

MIGRANT OUTREACH PROGRAMS

1. Baseline Mapping
 - a. Information about health profiles and needs of all migrant populations
 - b. Information about specific needs of Shan population
2. Improve Access to Appropriate Primary Health Care Services
 - a. Provide appropriate patient care and referral services
 - b. Provide effective RCH and other preventive services
 - c. Establish comprehensive EPI and nutrition services
 - d. Provide health education to address common migrant problems
 - e. Locate satellite clinics to facilitate use by women and children
 - f. Define criteria for selection of target communities, including experience from migrant health pilot projects in Tak, Chiang Mai, and Chiang Rai provinces
 - g. Assess resources available, including capacity of local Thai MoPH to be involved
 - h. Review emergency case needs and options to improve referrals, including transportation and clinic ethnic translators
 - i. Plan to phase in border rural target areas over a 3-5 year period
 - j. Systematic monitoring and evaluation
3. Strengthen Local Migrant Capability for Cooperative Health Care
 - a. Migrant community advocacy for access to Thai health care facilities.
 - b. Public education and information on means for accessing Thai health care systems.
 - c. Public education and support building for mobile health services.
 - d. Identify potential community leadership, Community Health Workers and volunteers to encourage community participation and inputs
 - e. Provide training and/or strengthen migrant CHWs, volunteers and district health staff in primary care, communicable disease control, reproductive health, and timely referral of ill individuals
 - f. Identify and train local individuals, particularly Traditional Birth Attendants and school teachers, in appropriate roles (maternal care, school health education)
 - g. Increase migrant and host community awareness of migrant health services

- h. Public education and information campaigns on public health and hygienic practices.
 - i. Institutional and public health service capacity building for NGOs/CBOs already experienced in serving Shan and other migrant communities.
 - j. Capacity building for CBOs with little such experience but other community presence indicia.
 - k. Systematic monitoring and evaluation.
4. Strengthen Collaboration Among NGOs and Donor Organizations
- a. Convene a Working Group of NGOs and donors to exchange migrant information and experience, discuss priority areas, and review opportunities for collaboration
 - b. Propose that the NGO coordinating committee, CCSDPT, consider establishing a Migrant Subcommittee or scheduled meetings to coordinate activities and plans
 - c. Invite the Migrant Subcommittee to review Ministry of Public Health policies that and guidelines that affect health services to migrants

CROSS-BORDER PROGRAMS

1. Improve Access to Appropriate Primary Health Care Services
- a. More systematic mapping and definition of health needs and characteristics of communities on Burma side of the border, using experience from Back Pack Medic projects in Mon, Karen, and Karenni states
 - b. Development of criteria for selection of target communities
 - c. Assess resources available, including capacity of donor support and policy
 - d. Review emergency case needs and options to improve referrals
 - e. Systematic small grants program
 - f. Coordination with UNICEF and WHO for purposes of planning and program development
 - g. Monitoring and evaluation tailored to particular conditions and challenges of border areas inside Burma

Appendix 4: NGO Organizational Chart

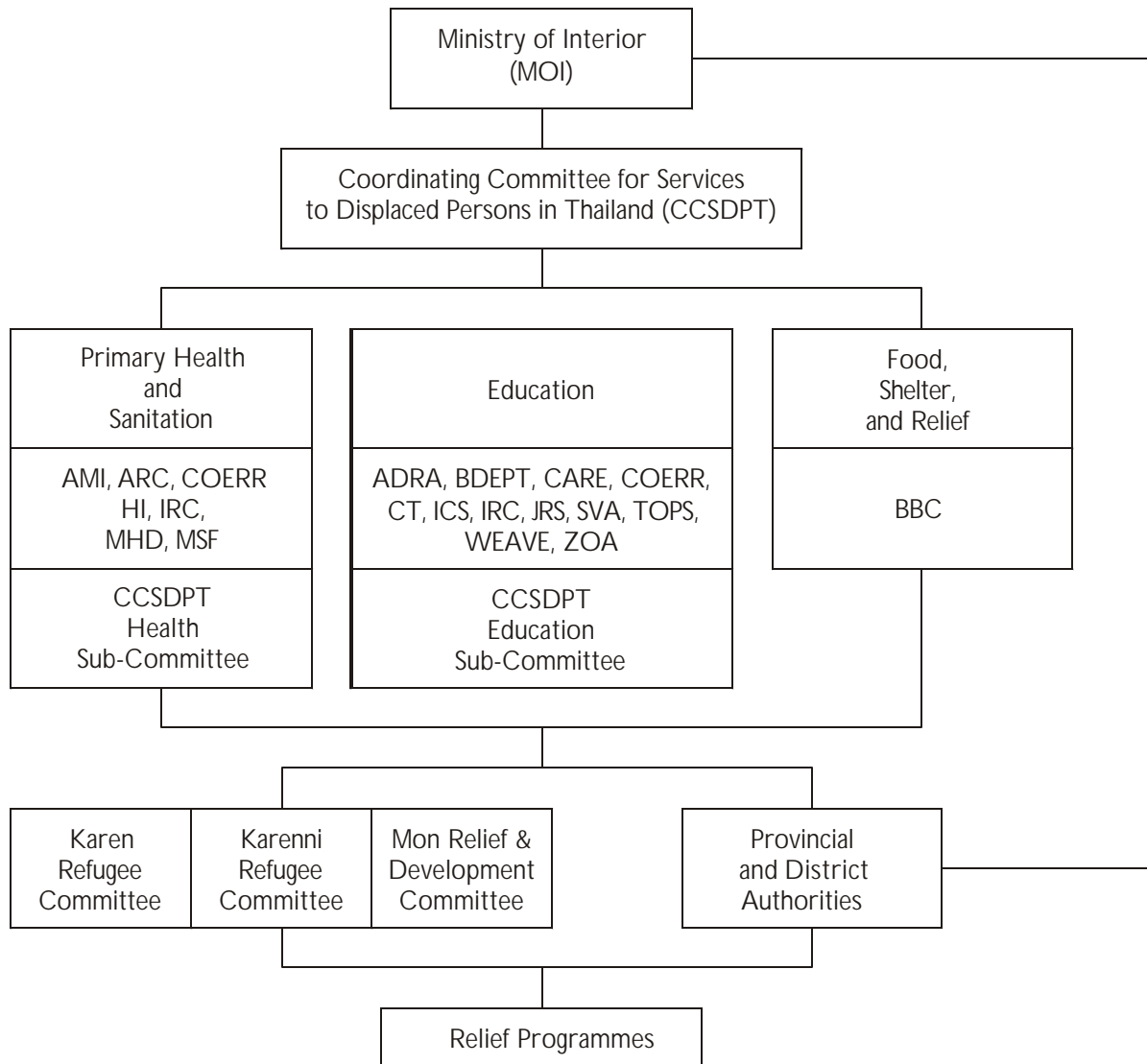
1. There is a diverse group of Non-Governmental Organizations (NGOs) providing humanitarian assistance to Burmese refugees/migrants in Thailand. Nineteen health and education NGOs in Thailand are members of CCSDPT (Committee for Coordination Services Displaced Persons in Thailand). Directors of these groups meet each month and a second day is spent in an open forum. Information exchanges, offers of assistance or materials, discussions of annual work plans, and efforts to develop explicit standards and guidelines (e.g. Burma Border Guideline for patient treatment) reflect a high level of cooperation. Members try to avoid duplications and submit their proposals for review under the appropriate subcommittee in Education or Health. (See Acronyms for names).

Refugees	Organization	NGOs and Activity Area		
		Health	Water/San	Food/Shelter
Karenni	NGOs	IRC, HI	IRC	BBC
(Sites 1, 2)				
(18,718)	CBOs	KnDD	KnDD	KnDD
<i>Kn Refugee Committee</i>		Kn Health Committee		
Karen	NGOs	AMI, Arc, HI, IRC	AMI, MHD, MSF	BBC
(Karen 1-7)			MHD, MSF, SMRU	ARC
(116,409)	CBOs	Mao Tao Clinic,	Kn Environment-	KESAN,
<i>Karen Refugee Committee</i>		others	Social Action	others
Mon	NGOs	MSF		BBC; MRDC
(resettlement sites)				
(12,326)				
<i>Mon Health Department</i>				
Shan	NGOs	BBC, IRC		BBC, BRC
(No official camps)				
	CBOs	Shan Health Department,		
		Shan Backpack Team		

2. These NGOs display a high degree of commitment to enabling refugee leadership to assume increasing responsibility for all aspects of the program. There is extensive training to help build capacity as managers, health workers, and teachers. The Camp Committee works with subcommittees in health, environment and food distribution.
3. Additional stakeholders include the RTG (Royal Thai Government), particularly the Ministries of Public Health (MoPH) and Interior (MOI). International organizations working in the refugee/IDP area are ICRC, IOM, UNHCR, UNICEF, WFP, and WHO.

Important donors are AusAID, CIDA, DFID, ECHO, EU, JIDEP, Norway, SIDA, and USAID.

NGO Organization Chart



- ADRA – Adventist Development and Relief Agency
- AMI – Aide Medicale International
- ARC – ARC International
- BBC – Burmese Border Consortium (Diakonia, IRC, NCA, TBMF, ZOA)
- BDEPT – Burma Distance Education Programme-Thailand
- CARE – Community Addiction Recovery and Education Project
- COERR – Catholic Office for Emergency Relief and Refugees
- CT – Consortium Thailand
- HI – Handicap International
- ICS – International Christelijk Steunfonds Asia
- JRS – Jesuit Refugee Service
- MHD – Malteser Germany
- MSF – Medecins Sans Frontieres – France
- SVA – Shanti Volunteer Association

TOPS – Taipei Overseas Peace Service
WEAVE – Women's Education for Advancement and Empowerment
ZOA – ZOA Refugee Care The Netherlands

Appendix 5: CCSDPT Coordination of Burmese Refugee Activities

The CCSDPT and its 19 NGO members appear to have achieved a remarkable level of sharing information at monthly meetings where they summarize information and interventions and even submit proposed work plans and new proposals for review through CCSDPT to the (MOI) Ministry of the Interior. This same coordination is desirable for migrant programs and for donor coordination.

Coordination of donors and NGOs is much praised but difficult to achieve. Agencies often have limited agendas, specialized expertise, and may compete for funding. At the same time, a coordinated group may achieve better negotiation with political or other stakeholders to achieve the “humanitarian space” they require for their programs: free access to clients and safety for aid workers and civilians (1).

One way to increase cooperation is to provide useful services and resources. Another is to provide key leadership for the coordinating group. An effective coordinator should be able to

- a. Facilitate an analysis (What are the issues and key questions? What are some of the options or strategies?) and
- b. Run an “effective meeting” (careful preparation, get key members to participate, attention to meeting process, and summarizing decisions and tasks).

The CSDPT is the forum for joint discussion and undertakes several functions recommended in coordination studies (1).

1. Service to members. The CCSDPT convenes a 2-day monthly Directors’ session, an open forum, and compiles information from their reports and studies in an annual report representing the broad refugee/migrant interventions in Thailand. There is a high monthly attendance rate indicating its perceived value for busy member NGOs.
2. Situational updates. These include analyses and implications for modifying or adding programs, including examples of well-run activities and programs.
 - a. This includes the identification of special opportunities and forming a work group to develop guidelines or proposals. Examples include an extensive Burmese Border Guidelines resource outlining patient treatment guidelines, with input by six NGOs, and a recent commissioning of a set of background papers in response to the UNHCR’s request for Contingency Planning for Repatriation of Burmese Refugees. These reflect a high quality of information exchange and critical thinking.
 - b. Best Practices. The CCSDPT encourages members to identify special resources that can be shared with other members. Examples are the comprehensive education expertise of the Consortium and the health worker training programs at the Mao Tao clinic.
3. Sub-Committees. Sub-Committees in Education and Health focus on programs and possible interventions.

These share training resources or ideas about standardizing training curricula and evaluation. Each Sub-Committee collects and discusses program reports, reviews, evaluations and lessons learned. These groups will be a forum to develop monitoring and quality improvement efforts.

- a. Data for decision-making about programs or strategies The CCSDPT does not allocate tasks, choose strategies or assign geographic areas. However, discussions about key issues or unmet needs, offers the background for decision-making.
4. Tasks to be considered. CCSDPT staff compile, analyze and prepare annual reports. It does not have programming resources to maintain a database of projects by sector and district. The annual meeting might attempt to identify program gaps or duplication and propose strategies to fill these gaps.
5. Collective representation. The CCSDPT presents annual reports to the MOI and donor agencies to create awareness about overall refugee and migrant programs. As noted above, it also presents new proposals for members to the MOI, helps to mobilize resources from donors, and provides the media with information and public relations material

There does not appear to be a comparable effort to coordinate humanitarian activities by donors in Thailand. With the potential repatriation of Burmese refugees to Burma, a very complex and difficult setting, a coordination mechanism will be critical to maximize donor planning, intervention strategies, and impact (see Repatriation). In talks with AusAID, DFID, UNHCR and USAID there seems to be a high interest in harmonizing donor activities.

1. Van Brabant K Opening the black box. An outline of a framework to understand, promote, and evaluate humanitarian coordination. June 1999. Humanitarian Policy Group. Overseas Development Institute. London.

Appendix 6: Morbidity and Mortality Statistics

1. The refugee age and gender distribution is important since it is related to disease patterns and health service needs. The camp refugee population is young with equal gender distribution. Most households have intact family structures, with only 6% single parent households. Typical household size is 5-6 members.

The refugee camp age group (years) distribution reported in December 2002 (CCSDPT) for 120,645 persons is:

Under 5	16% (infants 5%, 1-4 11%)
5-14	28%
15-44	45%
45 and older	21%

This distribution will varies among camps but is useful to estimate numbers in a target group and potential service workloads. For example, with equal gender distribution in all age groups, one quarter (23%) of a camp's population is in the female reproductive age group (15-44). Managers can convert program utilization figures into "coverage rates" by calculating the percentage of the target group (number of users/estimated number).

2. Vital statistics Based on reports from 7 of the 9 refugee camps (CCSDPT) and 2002 statistics from Burma and Thailand (UNICEF, 2003). The information is shown per 1000 population or per 1000 age group.

	Year	Crude BR	Crude MR	Infant MR	1-4 MR
a. Camps	2000	34.1	4.9	22.4	9.2
	2001	33.0	4.6	26.5	9.2*
	2002	30.3	4.4	25.0	6.8
b. Burma	2002	24		77	23.9
c. Thailand	2002	18		24	5.7

* The higher IMR in 2001 was attributed to a diarrheal disease outbreak

Several key results are found in the table. First, camp mortality rates are much better than those in Burma, and resemble those achieved in Thailand in 2002. In adjacent rural Thai villages, statistics may be worse. Second, the camp mortality rates are also stable, suggesting appropriate and effective curative and preventive services, particularly maternal and child health activities. Third, the camp birth rate is higher than either country. Depending on local needs and attitudes, this emphasizes the importance of Reproductive Health programs, including family planning. Forth, the excellent 1-4 year old mortality rate in camps reflects good clinical and preventive programs. A high 1-4 MR, particularly in year two, would have indicated the well-known synergism between infection and malnutrition. Finally, the recognition of "above average" rates, such as the 2001 1-4 MR, suggests that camp staff are using surveillance information to analyze and address underlying causes.

3. Disease surveillance (These are tabulated and reported on a monthly basis)

Condition	2000	2001	2002
Lower Respiratory Tract Infection (per 1000)	923	714	676
Skin diseases	199	158	225
Diarrheal disease (watery)	337	350	378
Dysentery (bloody)	97	82	104
Malaria (Over half is falciparum)	79	88	108
Typhoid fever		79	1.4
Dengue fever		63	1.2
Measles	variable levels reported		
Tuberculosis	3.0	2.7	2.4
Miscellaneous			
Sexually transmitted disease		1.5	3.7
Malnutrition			
Acute (W/H < 2 sd)		2.5% -----	4.3%
Chronic (H/age < 2 sd)		8.5%-----	43.2%
Beri beri (vitamin B1 deficiency)	147	89	65

This profile of patient problems reflects communicable disease transmitted by close crowding (respiratory infections, tuberculosis, scabies), water and personal hygiene (diarrhea, typhoid fever, skin diseases), and the mosquito population (malaria, dengue, Japanese encephalitis). It offers direction to in-service training and community health education activities. Most diarrhea cases are mild-moderate. All visited camp clinics have posted surveillance bar graphs for malaria, diarrhea, and acute malnutrition, all updated each month. These were used to recognize and address outbreaks of dengue fever and malaria by starting mosquito-spraying campaigns in and around the camps. There was no information about non-communicable diseases such as injuries, mental health, violence (under-reported), but referrals are made to local Thai hospitals (labor complications, general surgery, tubal ligation, stroke, cancer). Several camps are trying to use case definitions (e.g. "dysentery", "low birth weight"), reviewing reports, and giving regular feedback to clinic staff. One result is fewer "beri beri" cases to improved accuracy.

4. Camp programs designed to address health needs (CCSDPT, 2003) These high levels of preventive services reflect staff commitment, on-going training and supervision.

- a. Vaccine-preventable diseases: The recommended vaccinations have high coverage.
Measles 95+% TT² – pregnancy 90% BCG 100%
OPV3 99% DPT3 99% Hep B3 90+%
- b. Water-borne / sanitation problems: There are low rates of related infectious diseases.
Adequate potable water supplies and latrines. Health education.
- c. Nutrition: Acute malnutrition is under 4%. Camps conduct growth monitoring, follow up feeding program with home visits by CHWs, and provide food rations with blended foods. Almost all children receive Vitamin A supplements (99% of <5, 5-12).

Appendix 7: Refugees and Migrants

1. Refugees

The Thai definition of refugee is limited to “persons fleeing armed conflict”, much narrower than the international definition: “persons having a well-founded fear of persecution in their home country” (UNHCR). Non-refugees may be called migrants or displaced persons. The Thai government suspended screening of new applicants for asylum from Burma by the UNHCR in January 2004, with little advance notice (Zia-Zarifi). In June 2003 the Prime Minister said that the UNHCR had infringed on Thai sovereignty by granting protection to Burmese exiles without informing the government. Refugee status determination will resumed with the reestablishment of Provincial Admission Boards. In late 2004 UNHCR plans to conduct an extensive population registration along the border using a new computerized system, Project Profile (BBC 2004). Thailand has hosted refugees from Cambodia, Vietnam, Laos and Burma for more than 20 years. The influx of Burmese refugees has steadily risen since 1988. No one anticipated the length of conflict in Burma. The Burmese regime’s continuing persecution caused new waves of refugees. At present there are nine refugee border camps with about 150,000 residents, chiefly Karen and Karenni.

- a. Karen and Karenni: Once here, camp residents are subjected to severe constraints by the Thai policy of restriction to camps and refusal to allocate land for farming. An originally self-sufficient rural people have been rendered dependent on long-term assistance, including food, fuel and shelter. In spite of these extraordinary circumstances, camp refugees have maintained family structures, acquired new education and work skills, and persevered. NGOs have evolved as well. They have developed a low-cost, effective, and close working relationship with the refugee communities. Starting with roles in crisis interventions (emergency medical care, food, shelter), they now focus upon capacity building (training, experience in management, increasing responsibility) and advocacy to increase awareness of the plight of Burmese refugees. NGOs and donors seek to influence policies and actions in Thailand and Burma, particularly skill and vocational training to allow refugees to become self-sufficient once again upon return to their homeland.
- b. Mon: In the south border area Mon leadership was pressured to sign a ceasefire arrangement in 1995. Within a year they were relocated to designated areas across the border in Burma. Since these are not their original lands their refugee camps were just relocated. This situation emphasizes the importance of planned land allocations and monitored repatriation when it occurs.
- c. Shan: Shan refugees in northern Thailand are officially “migrants”. The RTG has not allowed official refugee camps. An estimated 150,000-200,000 or more Shan State refugees fled into northern Thailand since 1996 fighting in central Shan state. Most are adult farmers without formal education or vocational skills. They move about seeking work as seasonal laborers or farmers in orchards and farms. An estimated 1,000 a month are still entering Fang district, a significant number given the displacement of Shan from the border to relocation sites.

2. Migrants

Accurate health information about Shan migrants in Chiang Mai and Chiang Rai is unavailable. No Shan refugee camps have been allowed so that camp-based disease profiles (e.g. Karen and Karenni camp statistics) are unavailable. Given limited access to curative or preventive services, migrant mortality rates must resemble those found in rural Burma - malaria, dengue fever, respiratory infections, skin disorders, with high IMR and CMR (Attachment 6). The Mao Tao clinic in Mae Sot reports that malaria dominates satellite Burmese health post cases, with severe anemia the commonest reason for hospital referral. Migrant children have low vaccination rates and most Shan women use traditional birth attendants (Meng)

There are three unofficial camps (Lloi Tai Lent, Baan Kung Jor, Mae Fang Luang.) that contain only a few hundred Burmese refugees. The BBC and SYNG (food, supplies), the JRS (hospital referrals) and the BRC assist these refugees. Although Thai health services are open to non-Thais who can pay, migrants often live at some distance from facilities, lack transportation, and cannot afford fees. Furthermore, many existing rural MoPH clinics are understaffed or have no personnel on duty. As a result, few migrants receive appropriate MCH services. The policy for issuing Work Permits to non-Thais/migrants fluctuates. The government encouraged migrants in July 2004 to register for Work Permits for one year. A fee of almost \$100 was required for permit application and a medical examination, while a health insurance card was another \$40. Often migrants earn \$1-1.50 a day. Nevertheless, over 900,000 migrants applied.

3. Migrant Outreach Programs

Several lessons about the importance of community development and ethnic staff involvement were reemphasized in two Migrant Health Projects in three areas.

Component	IRC Phop Pra	IOM Tak and Chiang Rai
Baseline Assessment	Completed	-----pending-----
Job descriptions Curriculum design	Yes Linked	-----unclear----- Not all suitable for CHW
Trainers	Experienced	Various MoPH, hospital
Type HWs Selection	CHW, EHW By migrant community	Non-migrants; most left. MoPH – by education level
Type volunteers Role	CHV, EHV	? If any recruited Community
Supply procurement MoPH role	No problems Cooperation	Bureaucratic delays. Unclear Implementation Plan. Inappropriate CHWs
Project roles	Collaborate with MoPH but NGO runs mobile unit	NGO finances, some management
Outcomes and indicators	After 1 year mobile attendance ? 80%. Hospital workload ? 33%	Trainee outputs -----not operational yet-----
Future plans	Extend Migrant outreach to 3 other districts (20,000)	(Recruit ethnic CHWs, work with community leaders)

Several lessons were reemphasized.

- a. Migrant community trust is critical to any possibility of success. Project 2 in the above table did not involve any CBOs or ethnic community leadership. Ethnic Health Workers and Health Volunteers are one bridge to attracting migrants to programs. The success of the Pho Prah program was largely due to its participatory approach and credibility with the target communities. After one year of operation, migrant attendance at the health posts nearly doubled, while the hospital workload fell one third.
- b. Thai health authorities vary in their willingness to help Burmese migrants. It is important to try to work with the MoPH to address migrant health needs but it may require a phased approach.

References

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UNHCR Determination of Refugee Status. (A recognized refugee has the right not to be sent back to country of origin - re fouled).

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Appendix 8: Coordination

In a typical crisis situation NGOs often operate independently, noting delays in requests for information or assistance, possibly related to government lack of refugee administrative capacity and other resources. There are several obstacles to improving coordination (e.g. competition for funds; most groups have special targets or expertise which may not always match the clients' needs; in crisis focus is on speed, with feeling coordination may cause delays; coordination needs time, resources, and giving up some autonomy. Extra effort is needed to standardize reports or budget information and submit new reports). Donors can provide incentives to overcome these concerns, including rewarding participants.

Often, designating a lead organization for a sector can be helpful. The UNHCR has sometimes designated one organization as a major implementer, and several "intermediaries" who work with an array of other NGOs. A coordinated group may be able to achieve better negotiation with political power-holders and others to achieve the "humanitarian space" for their programs: free access to their clients and safety for aid workers and civilians. An effective coordination leader should be able to facilitate an analysis (what are the issues and key questions? What are some of the options or strategies?) and run an "effective meeting" (careful preparation, key members participating, attention to meeting process). NGOs may be more willing to cooperate on broad objectives or operational standards, but more reluctant to accept joint decisions and to coordinate implementation and strategies. In initial stages it is prudent to develop trust and cooperation by providing useful services and resources.

There are several areas that might be assigned to a central coordinator. Its tasks range from acceptable to members (a, b) to more controversial (c) areas for NGOs to share.

The list starts with acceptable and moves toward areas that require more trust:

- a. Services to Members
 - Serve as contact point. Develop an agency directory.
 - Provide situational updates by monitoring and evaluating available Needs Assessments and Resource Availability (financial resources, assets)
- b. Services to Agencies
 - Security. Incident updates and pattern analyses; technical support (e.g. radios)
 - Learning. Consider starting appropriate task forces along themes to facilitate information exchange, critical reviews
 - Training. Provide inventory of training; standardize training curricula; train
 - Evaluation. Collect and discuss program reports, reviews and evaluations carry out same. List lessons learned.
- c. Task- and Target-oriented functions
 - Programming. Maintain database of projects related to sector and district.
 - Collate sectoral policies and guidelines.
 - Review program gaps or duplication and possible operational roles to fill these gaps.
 - Political analysis. Analyze conflicts, agency positions, develop scenarios
 - Collective representation. An integrated presentation may enhance efforts to gain consent from power brokers, help mobilize resources from donors, and provide the media with information and public relations material

- Strategic decision-making. Discuss key issues.
- Allocation of tasks or division of labor. Selection or vetting of agencies; incentives for various efforts

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USAID. Development experience clearinghouse. Uganda. Delivery of improved services for health (DISH II). Putnam E, et al. March 2003 (This report is of interest for its methods, organization, comments on Grants Program, and advice to help subsequent implementers and donors. It emphasizes the value of explaining the purpose of an assessment and inviting frank discussions of strengths and weaknesses. During discussions, they ask for inputs about grants, technical assistance, and logistics.)

Van Brabant K Opening the black box. An outline of a framework to understand, promote, and evaluate humanitarian coordination. June 1999. Humanitarian Policy Group. Overseas Development Institute. London.